UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEWEL ANDERSON,	:	
Plaintiff,	:	
- against -	:	07 CV 6256 (DC)
LIFE INSURANCE COMPANY OF NORTH AMERICA,	:	AFFIDAVIT OF RICHARD LODI
Defendant.	:	

COMMONWEALTH OF MASSACHUSETTS)
) ss:
COUNTY OF WORCESTER)

I, RICHARD LODI, being duly sworn, depose and state as follows:

1. I am employed by Life Insurance Company of North America ("LINA") as a Senior Operations Representative. I make this affidavit in support of LINA's motion to transfer venue in the above-captioned action.

2. As part of my job responsibilities, I am familiar with plaintiff Newel Anderson's claim for long term disability benefits under the long term disability policy issued by LINA to plaintiff's employer, FLK 30052, to fund the employer's benefit plan ("Plan"). The Plan is administered by the employer, Aegon, USA, which is based in Cedar Rapids, Iowa. LINA administers benefits claims under the Plan. I am also familiar with LINA's claim file pertaining to Anderson's claim (the "Claim File"), which has been routinely kept by LINA in the ordinary course of its business.

3. LINA is a Pennsylvania company with its principal place of business in Philadelphia, Pennsylvania.

4. LINA administered Anderson's long term disability claim in its claim office in Pittsburgh, Pennsylvania.

5. Attached hereto as Exhibit A is a true and correct copy of a Long Term Disability Proof of Loss dated September 26, 2006 which was submitted by Anderson to LINA in support of his claim for long term disability benefits under the Plan. This document is contained in LINA's claim file. The form shows that plaintiff's address is in Suwanee, Georgia. The form also shows that plaintiff's treating medical providers were located in Georgia.

6. Plaintiff's treating physician Cynthia Lawrence Elliott is located in Lawrenceville, Georgia. Attached hereto as Exhibit B is an Attending Physician's Statement completed by Dr. Lawrence Elliott on May 23, 2006, which is located in LINA's claim file.

Richard Lodi

Sworn to and Subscribed before me this
1 day of November, 2007

Notary Public
Expires April 14, 2011

CERTIFICATE OF SERVICE

I hereby certify that on November 1, 2007, a copy of the foregoing Affidavit was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

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Exhibit A

Long Term Disability

Proof of Loss

CIGNA Group Insurance
Life • Accid Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

FRAUD WARNING: Any Person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purposes of misleading, information concerning any material fact, commits a fraudulent insurance act. For residents of the following states, please see the reverse side of this form: California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas, or Virginia.

EMPLOYEE INFORMATION

Name of Employee (Last, First, Middle):	Date of Birth:	Incident #:	Sex:
ANDERSON, NEWEL Richard Jr.	07/12/1955	1499576	☒ Male ☐ Female ☐ Unknown

Address (Street, Apt): 1155 ANTHONY COURT

City:	State:	Zip Code:	Telephone No.:
SUWANEE	GA	30024	(770)888-9331

Please describe your condition: not specified

PLEASE COMPLETE SECTIONS A, B, OR C - AND THE REMAINDER OF THE APPLICATION

A	Is this an injury? ☐ Yes ☒ No ☐ Unknown	Date of Injury:	Time of Injury:	Is this work related? ☐ Yes ☐ No ☐ Unknown

Describe the cause of Injury:

B	Is this an illness? ☒ Yes ☐ No ☐ Unknown	Date of Illness: Nov 2003		Is this work related? ☐ Yes ☒ No ☒ Unknown

Describe the cause of Illness: unknown

C	Is this an pregnancy? ☐ Yes ☒ No ☐ Unknown	Delivery/Due Date:	Delivery Method:	Were there complications? ☐ Yes ☐ No ☐ Unknown

Describe the complications:

Are you currently losing time from work? ☒ Yes ☐ No ☐ Unknown	If yes, what specifically prevents you from working? ~~mental/physical~~ primarily absolute mental and physical exhaustion-mental confusion and memory loss	
Last Day Worked: 04/06/2006 # hours worked: 7.00	Date first unable to work: 04/07/2006	Date you plan to return to work? ?
Have you had the same or similar condition in the past? ☒ Yes ☐ No ☒ Unknown	If yes, when did it occur (dates)? Aug 2004	Please describe: STD for same conditions

Please list any states in which you may be liable for filing tax returns: GA

Are you receiving any other income or benefits? If so, please complete the following.

Benefit Type	Gross Weekly Amount	Date Began	Paid thru Date
N/A			

Please list any hospitals, clinics or physicians that treated you for your condition:

Name & Address	Telephone No.	Specialt.	First Treatment Date	Last Treatment Date
SHAHID RAFIQUE 2351 HENRY CLOWER BLVD ROSWELL, GA 30076-	(770)736-1735	Family Practi		
Cynthia Elliott 600 Professional Dr Lawrenceville, GA 30045	770 822 1090	Rheumatology	May 2006	Sep 2006

EMPLOYMENT INFORMATION

Occupation:	Date Hired:	Basic Earnings: Frequency:	Date of last change in earnings:
01 - Officials and Managers VP CHEIF COMM	02/01/1995	$ 1.00 Weekly	

Please provide a brief description of daily job duties:
Primarily Database programming of the commission system

Please check the appropriate items regarding this employee:
- ☐ Exempt ☐ Non-Exempt ☐ Management ☐ Non-Management
- ☐ Supervisory ☐ Non-Supervisory ☒ Salaried ☐ Hourly
- ☒ Full Time ☐ Part Time Hours/Week
- ☐ Union - Local # ☐ Non-Union

Has Employee been laid off? ☐ Yes ☒ No ☐ Unknown
Or terminated? ☐ Yes ☒ No ☐ Unknown
If yes, please indicate the date and reason:

STD Policy/Covg. Number:	Effective date of employee's STD coverage:	Was STD insurance issued on the basis of a statement of physical condition? ☒ Yes ☐ No ☐ Unknown
Percent of Employee's STD contribution: %	Employee's contributions were made on: ☐ Pre-Tax Basis ☐ Post-Tax Basis	Premium Paid Thru Date:
LTD Policy/Covg. Number:	Effective date of employee's LTD coverage:	Was LTD insurance issued on the basis of a statement of physical condition? ☐ Yes ☐ No ☒ Unknown
Percent of Employee's LTD contribution: %	Employee's contributions were made on: ☐ Pre-Tax Basis ☐ Post-Tax Basis	Premium Paid Thru Date:

I do not know these things

2.

EMPLOYEE WORK LOCATIONS

Employer Name:	Contact Person:
AEGON USA, INC	Dwight Ward
Address (include Street, City, State & Zip): 11315 Johns Creek Pkwy WORLD FINANCIAL GROUP UNKNOWN DULUTH GA 30097-	Telephone No.: 770-453-9300

ADDITIONAL EMPLOYERS (If applicable)

Employer Name:	Contact Person:
Address (include Street, City, State & Zip):	Telephone No.:

Name of Employee (Last, First, Middle):	Social Security Number:
ANDERSON, NEWEL Richard Jr.	585-78-9025

CERTIFICATION

This is to certify the facts as indicated above are true to the best of my knowledge and belief.

Signature of Employee: Newel Richard Anderson Date of Signature: 9-26-06

The issuance of this form is not an admission of the existence, nor does it recognize the validity, of any claim and is without prejudice to the company's legal rights in the premises.

Exhibit B

5/23/06

AEGON

Attending Physician's Statement
AEGON Short-Term Disability Program

The Employee is responsible for the completion of this form without expense to the Employer.

1. To be Completed By Employee

Employer Name: ~~Horizon~~ ~~Rockwood Anderson~~ World Financial Group		
Employee Last Name: Anderson	MI: R	Social Security Number: 585-28-9025
Employee First Name: Newel		Employee ID Number: 000271429
Employee Address - Line 1: 1155 Anthony Court		Date of Birth (MM/DD/Year): 07/12/2006
Employee Address - Line 2		☒ Male ☐ Female
City: Suwanee	State: GA	Zip Code: 30024
Job Title: Vice President - Aristotle Communications		

I hereby authorize release of information requested on this form for the purpose of claim processing.

x Newel Richard Anderson — Employee Signature — Date Signed: 5/23/2006

2. To Be Completed By Attending Physician

Clinical Diagnosis — ICD-9 Code

Primary: ~~Viremia~~ Chronic Viremia	795 . 79	Chronic Viremia ABN immunological fatigue & weakness multiple joint pain
Secondary: Fatigue + Weakness	780 . 79	
Secondary: Multiple joint pain	719 . 40	

☒ Totally Disabled From ~~to~~ 5/23/06 to Present

☐ Partially Disabled From ____ to ____

# of hours the employee can work per day: N/A

Prognosis for Return to Work Part Time: POOR

Prognosis for Return to Work Full Time: POOR

Date of First Visit / / Date of Last Visit 05/23/06 Frequency of Visits 2 to 3 wks

Relevant test procedures performed (Please provide results): Serologies attached

Surgical procedures(s) performed (Please be specific): N/A Date of Procedure: / /

Current Medications: None

Was Claimant hospital confined? ☐ Yes ☒ No

If Yes, please provide name and address of hospital:

If hospitalized, give dates: From: / / To: / /

Other Treating Physicians or Consultants

Physician Name	Specialty	Phone Number

AEGON Employee Service Center
Disability Unit, MS 3855
4333 Edgewood Road NE
Cedar Rapids, IA 52499
Fax 319-558-5401

2. Attending Physician Information (continued)

Nature of Medical Impairment / Limitation (Please specify nature of corresponding loss of function): Auto immune illness - with protracted course of viremia

Date when significant loss of function occurred: 10/15/2003 by History

Are there Corresponding Medical Restrictions, i.e., what activities should the claimant not perform because of a significant risk to self or others? Repetitive lifting

Can the patient perform sedentary work? ☐ Yes ☒ No

What treatment will be followed to alleviate the current restrictions? Conservative approach / supportive care

Return to Work Plan (Please describe): N/A Target Date: / /

Describe Medical Obstacles to Return to Work: N/A

Are there any Non-Medical Factors which have a significant impact on Functional Abilities, i.e., interpersonal, financial, family? N/A

Work related illness or injury? ☐ Yes ☒ No

Was Condition caused by a MVA? ☐ Yes ☒ No N/A

What Job Category best describes the claimant's functional abilities? (Please check appropriate box)

☐ Sedentary	☐ Light	☐ Medium	☐ Heavy	☐ Very Heavy
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally	10 to 25 lbs. freq. Up to 50 lbs. occ.	25 to 50 lbs. freq. 50 to 100 lbs. occ.	More than 50 lbs. freq. 100 lbs. occasionally

3. Physician Information

Physician Name: Cynthia L. Elliott	Specialty: Rheumatology	Phone Number: 770-622-5282	
Office Address: 600 Professional Dr. Suite 260		Fax Number: 770-622-5286	
City: Lawrenceville	State: GA	Zip Code: 30045	

The above statements are true to a reasonable degree of medical certainty.

X _____ Date Signed: 05/23/06

Physician Signature

Cynthia C. Elliott MD

Printed Name

Important: This form must be completed and signed by one of the following: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Dental Surgeon (D.D.S.), Podiatrist or Surgical Chiropodist (D.P.M. or D.S.C.) or Chiropractor (D.C.)